

# Comprehensive Waiver Application Overview



**THE NJ DEPARTMENT OF HUMAN  
SERVICES**

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# What is a Comprehensive Waiver?

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The Comprehensive Waiver is a collection of reform initiatives designed to:

- sustain the program long-term as a safety-net for eligible populations
- rebalance resources to reflect the changing healthcare landscape
- prepare the state to implement provisions of the federal Affordable Care Act in 2014

# Why Do We Need a Waiver?

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- Medicaid programs are matched – in part – with federal funding; all changes to the program must be approved before implemented
- NJ has 8 Medicaid waivers (including CCW) for various programs/services; need to consolidate to reduce administrative burden
- Medicaid grew in cost by 18% over 3 years; state must spend resources efficiently

# Comprehensive Waiver Development

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- February 2011 - Governor Chris Christie calls for a Medicaid reform plan during FY'12 budget address
- February 2011 to May 2011 – DHS, DHSS, DCF review every facet of the program, examine other states' plans, look at every possible opportunity to improve and to reform
- May 2011 - Waiver concept paper is released
- May 2011 to August 2011 - Extensive public input process
- August 2011 to September 2011 – Input is reviewed/concept paper revised/waiver application drafted and finalized
- September 2011 - Waiver is submitted to CMS/posted on DHS website

# Stakeholder/Public Input

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## Support for:

- Structural reform
- Enhanced services for underserved populations
- Preserving eligibility criteria
- Reinvestment of savings into community-based services

## Opposition to:

- Freezing AFDC/TANF+ parent population
- ER co-pay for non-emergency visits

# Waiver Highlights

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- Model for reform and innovation
- Streamlines program administration and operation
- Preserves eligibility and enrollment
- Does not include ER co-pay
- Enhances and coordinates services to specialty populations
- Rewards efficiency in care

# The details by category

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**WHAT DOES IT ALL MEAN?**

# What does Medicaid Waiver mean for Behavioral Health services?

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- Integrates behavioral health and primary care
- Develops innovative delivery systems – MBHO, ASO
- Supports community alternatives to institutional placement
- Braids funding
- Provides opportunities for rate rebalancing
- No-risk model transitions to risk-based model
- Increased focus on children, SAI and consumers with developmental disabilities

# Need for Care Integration

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- Currently, BH care under Medicaid FFS is fragmented with an over-reliance on institutional, rather than community-based care
- Consumers receive care through managed care organizations (MCOs) with limited or no formal protocols for coordination between medical and behavioral health delivery systems
- Approximately two-thirds of Medicaid's highest cost adult beneficiaries have MI and one-fifth have both MI and a substance use disorder.

# Delivery System Innovations

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## Clinical Service Model:

- Uniform screening and assessment
- The SAMHSA 4-quadrant model
- ASO/MBHO clinical role
- Behavioral health homes, Accountable Care Organizations
- Special initiatives

# Community vs. Hospital based Care

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- Behavioral health care will be delivered through an administrative services organization (ASO)
  - Begins January 2013
  - Uniform screening and assessment
  - Behavioral health homes/case management/risk model
  - Reliance on community-based settings
  - Manage Medicaid funding, block grant and state-only dollars

# Waiver Impact on Access, Quality, Outcomes

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- State sets client outcome benchmarks for MBHO and performance measures for network participation
- Allows for consumer and family participation in the design and ongoing monitoring of access and quality outcomes
- Per the 'medical loss ratio' provision, MBHO must spend majority of resources on care
  - Sets minimum amount on services
  - Limits maximum administrative spending
  - Limits maximum profit to be earned
  - Reinvestment in new capacity

# Aspects of the Risk Model

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- Non-entitlement services remain non-risk
- Increased opportunities for Medicaid reimbursement for the first 30-days of community-based residential treatment services - individuals age 22 to 64
- Increased ability to capture savings generated from improved, coordinated BH services
- Greater assurance of meeting budget neutrality projections through capitation
- MBHO has more flexibility to develop new services
- Provides incentives for clients to be served in the least restrictive and least costly level of care

# Bottom Line – Good News

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- Integrated care SA/MH and BH/PH
- Opportunities for rate rebalancing
- Increase FFP
- Service expansion for SA services
- Reinvestment of some savings
- Reimbursement for community-based services instead of acute care
- Better access, enhanced quality, improved outcomes

# Expected Challenges

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- Timely communication
- Consumer involvement to ensure ease of access
- IT infrastructure
- Moving from non-risk to risk
- Managing eligibility and enrollment
- Coordination between MBHO and MCO
- Defining outcome measures to gauge performance

# What are the next steps?

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- Federal review of the waiver application
- Informal and formal communications with CMS on waiver elements
- CMS submits waiver questions
- NJ responds to CMS questions
- CMS/NJ negotiations
- Waiver approval/denial

# What is the tentative timeline for implementation?

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- January 2012 – SNPs offered, expanded support to I/DD
- July 2012 – managed LTC, streamlined eligibility for LTC support
- July 2012 – BH services to children expand
- January 2013 – managed BH organization implementation

# More information

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- The full waiver application can be found online at:  
[www.state.nj.us/humanservices/](http://www.state.nj.us/humanservices/)
- Comments can be emailed to  
[CMWcomments@dhs.state.nj.us](mailto:CMWcomments@dhs.state.nj.us)